SUBSTANCE ABUSE
2021, VOL. 42, NO. 1, 5–12
https://doi.org/10.1080/08897077.2020.1867288

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COMMENTARY

Dismantling racism against Black, Indigenous, and people of color across the substance use continuum: A position statement of the association for multidisciplinary education and research in substance use and addiction

Holly N. Hagle, PhD[a], Marlene Martin, MD[b], Rachel Winograd, PhD[c], Jessica Merlin, MD, PhD, MBA[d], Deborah S. Finnell, DNS, RN, CARN-AP, FAAN[e], Jeffrey P. Bratberg, PharmD, FAPhA[f], Adam J. Gordon, MD, MPH[g,h], Cheyenne Johnson, MPH, RN, CCRP[i], Sharon Levy, MD, MPH[j], Doreen MacLane-Baeder, BA[k], Rebecca Northup, MAT, MA[k], Zoe Weinstein, MD, MS[l], and Paula J. Lum, MD MPH[m]

[a]School of Nursing and Health Studies, University of Missouri, Kansas City, Missouri, USA; [b]School of Medicine, University of California, San Francisco, California, USA; [c]Missouri Institute of Mental Health, University of Missouri, St. Louis, Missouri, USA; [d]Department of Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania, USA; [e]Johns Hopkins School of Nursing, Wolfe, Maryland, USA; [f]Department of Pharmacy, College of Pharmacy, University of Rhode Island, Kingston, Rhode Island, USA; [g]Department of Substance Abuse, University of Utah, Salt Lake City, Utah, USA; [h]Department of Internal Medicine, Division of Epidemiology, Program for Addiction Research, Clinical Care, Knowledge and Advocacy (PARCKA), VAMC, University of Utah School of Medicine, Salt Lake City, Utah, USA; [i]British Columbia Centre on Substance Use, Vancouver, British Columbia, Canada; [j]Department of Pediatrics, Harvard Medical School, Boston Children's Hospital, Boston, Massachusetts, USA; [k]Association for Multidisciplinary Education and Research in Substance Use and Addiction, Cranston, Rhode Island, USA; [l]Clinical Addiction Research and Education Unit, Boston Medical Center, Boston, Massachusetts, USA; [m]HIV/AIDS Division, Positive Health Program, University of California, San Francisco, California, USA

ABSTRACT

The Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA) acknowledges that racism profoundly affects persons who use alcohol and other drugs. Racism's deadly effects compounded with other social determinants of health result in a cascade of negative impacts. The AMERSA Board of Directors (BOD) proposes an initial set of strategies to promote diversity, equity, and inclusion using a framework that speaks to four key AMERSA experiences: engagement, education, mentorship, and leadership. Through these strategies, AMERSA commits to promoting equity and inclusion to dismantle the individual, institutional, and structural racism that has permeated the United States for centuries. Abstracts of paper and poster presentations are also provided (Supplemental Material).

KEYWORDS

Substance use; racism; social determinates of health

Executive summary

Recognizing that racism has profound effects on persons who use alcohol and other drugs, the Association for Multidisciplinary Education and Research in Substance use and Addiction (AMERSA) commits to promoting equity and inclusion to dismantle the individual, institutional, and structural racism that has pervaded the United States for centuries. Racism's deadly effects compounded with other social determinants of health result in a cascade of negative impacts. These include higher rates of incarceration, increased risk of overdose, fewer employment options, multi-generational poverty and economic disadvantage for Black, Indigenous, and People of Color (BIPoC). Exposing and eliminating deep-seated racial inequities in the substance use and health and behavioral health fields requires understanding and addressing racism's role in (1) the creation, enforcement, and propagation of drug laws; (2) access to and provision of high-quality and stigma-free services for persons who use drugs; and (3) greater representation of BIPoC as both investigators and participants in substance use and addiction research. The status quo is unacceptable.

The AMERSA Board of Directors (BOD) proposes an initial set of strategies to promote diversity, equity, and inclusion using a framework that speaks to four key AMERSA experiences: engagement, education, mentorship, and leadership. Through interprofessional leadership in evidence-based substance use education, research, policy, and clinical practice, AMERSA commits to transformative change.

Background

The Association for Multidisciplinary Education and Research in Substance use and Addiction (AMERSA) recognizes that the individual, institutional, and structural racism that permeates substance use and addiction care must be dismantled through actions that promote equity and inclusion across cultural, linguistic, and racial boundaries.

CONTACT Holly N. Hagle, PhD hagleh@umkc.edu School of Nursing and Health Studies, University of Missouri-Kansas City, Health Sciences Building, 2464 Charlotte St., Suite 2429, Kansas City, MO 64108, USA.

Supplemental data for this article can be accessed on the publisher's website.

This article has been republished with minor changes. These changes do not impact the academic content of the article.

Eliminating these inequities requires understanding and addressing the interplay of racism and social determinants of health and racism's role in 1. creating, enforcing and propagating drug laws; 2. access to and provision of substance use services; and 3. representation of BIPoC investigators and participants in substance use and addiction research. In this position statement, we provide an overview of these concepts and issues and propose steps AMERSA is taking to address them.

Interplay of racism and social determinants of health

Racism is the belief that all members of a purported race possess characteristics, abilities or qualities specific to race and is a particular form of prejudice directed toward a person or group of people based on their membership of a particular racial or ethnic group.[1] Race is an artificial construct––a myth––not a biological construct.[2] Racism is a system of structuring opportunity, which unfairly disadvantages some individuals and communities while unfairly advantages others and undermines the realization of the full potential of all members of society.[3] Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems such as housing, education, employment, earnings, benefits, credit, media, health care, and incarceration.[4]

Racism and discrimination against BIPoC intersects with social determinants of health, factors that take into account race, ethnicity, gender identity, sexuality, citizenship status, socioeconomic status, education, neighborhood, physical environment, employment, social support networks, and access to health care.[5] These conditions in which people are born, grow, live, work, and age must be considered in the context of public health issues,[6,7] including substance use. Racism is inextricably linked to social determinants of health given the increased likelihood of BIPoC to live in poverty, experience trauma, and lack these very foundational contributors to health and well-being.[8]

Racism is practiced on multiple levels: interpersonal, institutional, and structural. For example, BIPoC are less likely than others to have health insurance that covers timely access to behavioral health services (structural),[9] receive evidence-based prevention curricula in school (institutional),[10] and receive treatment instead of arrest and incarceration for drug-related offenses (interpersonal and structural).[11] The negative impacts on the overall health of BIPoC are compounded through implicit and explicit biases, institutional structures, and interpersonal relationships.[12] Further, racial and ethnic health disparities are responsible for differential care within healthcare systems, differential access to healthcare and differential exposures and life opportunities.[3] It is imperative to understand how racism creates disparities for BIPoC, because disparities are differences in health that are unnecessary and avoidable, unfair, and unjust.[13]

Creating, enforcing and propagating drug laws: the racist war on drugs

Even prior to Richard Nixon's 1971 declaration of a "War on Drugs," BIPoC have been consistently and disproportionately arrested, charged, prosecuted, and incarcerated for drug-related offenses.[7] Particular drugs have been associated with groups of marginalized and stigmatized "others" that are almost always people of color.[14–16] The first anti-drug law in the U.S. was the city of San Francisco's *Opium Den Ordinance* of 1875, adopted during a wave of anti-Chinese immigration sentiment that culminated in the Chinese Exclusion Act of 1882. The proponents of the federal *Marihuana Tax Act of 1937* applied similar tactics to demonize the large migration of Mexican farmworkers into the Southwest and California in the 1920s and to associate cannabis use by "Negroes, Hispanics, and Filipinos" with crime, violence, and madness.[17,18] In the year following the law's passage, Mexicans were nearly nine times more likely to be arrested for violating narcotic drug laws than Whites, projecting biased and stigmatizing cannabis use on Mexicans.[18,19] Nixon's "War on Drugs," which began officially with the establishment of the Office of Drug Abuse Law Enforcement in 1972, was subsequently described by John Erlichman, Nixon's Assistant for Domestic Affairs, as a political war waged on anti-war protestors and Black communities:

> The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and Black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or Black, but by getting the public to associate the hippies with marijuana and Blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.[20]

BIPoC are no more likely than Whites to use illicit drugs, but they are 6–10 times more likely to be incarcerated for drug offenses.[21–24] In the US since the 1980s, aggressive law enforcement strategies to curtail the use and distribution of illegal drugs has been waged primarily against Black individuals.[25] Notably, the federal Anti-Drug Abuse Acts of 1986 and 1988 imposed far higher penalties for possession or sale of crack cocaine than powder cocaine. This is a society where crack cocaine is portrayed as a drug of the Black inner-city urban poor, while the use of more expensive powder cocaine is associated with wealthy Whites. From 1988-1993, Blacks were arrested in the U.S. at rates more than five times the rate of Whites,[25] and the average federal drug sentence for Blacks rose from being 11% longer than Whites in 1986 to 49% longer in 1990.[26] This extensive history of anti-drug laws and the criminalization of substance use include not only higher rates of arrest and incarceration,[11] but also physical injury,[27] and loss of custody of children.[28] These events create "ripple effects" for BIPoC including exclusion from the job market and voting. The creation, enforcement, and propagation of drug laws in the U.S. through a racist war on drugs only reinforces false racial

hierarchies and contributes to the health disparities and lost opportunities that BIPoC experience.[21]

Substance use treatment and harm reduction services: racial disparities in access and outcomes

While the prevalence of substance use disorders (SUDs) in the U.S. is similar (about 8%) among White, Latina/o, and Black populations, BIPoC groups suffer more negative consequences and decreased access to evidence-based treatment and harm reduction services than others.[27,29] The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that despite similar rates of opioid misuse as in the general population, Blacks in recent years have experienced the greatest increase in fatal overdose rates from non-methadone synthetic opioids.[29]

Clear differences in society's response to drug use between White and BIPoC communities underscore systemic and structural racism in action. For example, we have noted earlier the punitive response to heroin or cocaine use in largely urban BIPoC communities. This stands out in stark comparison to the more legitimized public health treatment response to the recent opioid analgesic overdose epidemic in largely White rural and suburban communities.[30]

Addiction treatment has been for too long less accessible for BIPoC patients and does not address the complex social determinants of health that intertwine with unhealthy substance use.[31] According to National Survey on Drug Use and Health data from 2018, Blacks and Latinos have much lower access to substance use treatment and mental health services, even though their rates of behavioral health disorders are similar to that of the general population. In 2018, 88% of Blacks and 90% of Latinos with SUDs received no treatment, and 69% of Blacks and 67% of Latinos with mental health disorders received no treatment. Instead, Blacks and Latinos with mental health and SUDs were more likely to be incarcerated and homeless.[29] Other examples of racial and ethnic disparities are the higher rates of office-based buprenorphine treatment in geographic areas with lower concentrations of Black and Latina/o residents and the higher concentration of more stringently regulated methadone clinics in communities of color.[7,32,33] This creates a lack of evidence-based treatment choices for everyone and undermines the full potential of all members of society.[3,32,33]

There is a complex intersection between racism, health disparities, and inequity. This intersection undermines the quality of life for BIPoC through the reciprocal interplay between inequality and inequity in access to care, education, housing, and employment, to mention a few.[34] Differential treatment retention is also evident among Black people receiving treatment for opioid, alcohol, stimulant, and cannabis use disorders.[35,36] Reasons for lower engagement and retention of Black individuals in SUD treatment are poorly studied, but likely due to less social, financial, and environmental supports, a lack of culturally-informed and responsive treatment, mistrust in the healthcare system, and unequal enforcement of treatment rules and requirements.[7,35,36]

We would be remiss if we did not also address racial disparities in harm reduction and other services for persons who use drugs. Harm reduction refers to pragmatic interventions aimed at minimizing the negative effects of unhealthy behaviors without a prerequisite that the behavior(s) cease.[37] Harm reduction practice respects the autonomy and humanity of persons with compassion and without moral judgment. For persons who use drugs, interventions such as sterile syringe access, naloxone training and distribution, housing first programs, and safer consumption spaces are lifesaving examples. However, we know that these services have not been equitably distributed across our communities.[7,32,33] While several U.S. cities such as San Francisco, Philadelphia, Seattle, Denver and Boston are taking action to develop and implement supervised injecting facilities (SIFs) [the AMERSA BOD has supported legislation in Pennsylvania and California], these cities must also acknowledge and navigate the forces of White privilege paving their paths. Historically, Black and brown people who smoked crack cocaine were stripped of their property and imprisoned as felons under the federal crack house statute of the Anti-Drug Abuse Act of 1986. When a federal judge ruled in 2019 that a Philadelphia-based SIF would not violate this same statute, some members of the Black community pointed out the differential treatment applied to a public health intervention serving primarily White persons who inject opioids.

What can be done to ensure equitable access to harm reduction services and fair application of policy in the shadows of this history? Some have called for reparations to address the race-based harms of the war on drugs and culturally-informed overdose prevention sites that serve persons using all drug types and routes of administration.[3,38] Harm reduction programs also can incorporate specific anti-racist and anti-oppression practices to improve initial engagement and long-term retention of BIPoC, as was done to significant benefit with a Housing First program in Toronto for ethnically diverse homeless adults with mental illness.[39] Anti-racist and anti-oppressive principles include empowerment, education, alliance building, language use, alternative healing strategies, advocacy, social justice/activism and fostering reflexivity. These principles drove a practice that provided clients with immediate access to permanent housing of their choice in their preferred neighborhood, as well as individualized and client-driven support plans focused on empowerment and choice. The Housing First program provided staff training in these practices, linguistic and culturally accessible programming and services, and an inclusive and welcoming physical environment for people from ethnic minority groups.[39]

We insist that all persons who use drugs be treated with compassion and lifesaving services driven by antiracist and anti-oppressive principles—whether they seek effective drug treatment options or the tools and resources to reduce the harms of ongoing drug use. We cannot afford to continue to ignore the structural racism that underlies substance use treatment and harm reduction services for persons who use drugs.

Racism and research

Dr. Nora Volkow, The National Institute on Drug Abuse (NIDA) Director, in a recent commentary wrote:

> NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. Science has told us repeatedly that systematic, widespread discrimination of Black/African-American people is diametrically opposed to these aims, and what's more, it is unacceptable and wrong.[40]

BIPoC have been disproportionately underrepresented in substance use and addiction research.[21,41] Jules Netherland and Helena Hansen have reflected on the Whiteness of neuroscience and the silence in the neuroscientific literature about the role of social and environmental factors contributing to addiction.[21] They state that social determinants of health are largely omitted from the description of research participants and from the lists of relevant variables in neuroscientific papers. Environmental factors in addiction neuroscience are generally reduced to cues or triggers (for example, studies demonstrating how the brain 'lights up' when a person who uses drugs is shown an image of heroin or cocaine).[21] These factors ignore the drivers of addiction and limit the generalizability of findings to BIPoC, further marginalizing BIPoC from accessing quality addiction care. In addition, a justifiable mistrust by BIPoC of scientific research exists in the shadows of historical events such as the "Tuskegee Study of Untreated Syphilis in the Negro Male" experiment and is further deepened by implicit and explicit discriminatory events that occur in health systems.[42] Mistrust of health systems and research is a barrier to participation in research that is expressed across racial/ethnic groups. Low access to information, fear of unintended outcomes, stigma, legal status and lack of health insurance coverage have all been reported as barriers to research participation by BIPoC.[43]

Not only is there underrepresentation of BIPoC as research participants, but there is a historical underrepresentation of BIPoC in academia.[44–46] BIPoC were more underrepresented in 2016 than in 1990 at the assistant, associate, and full professor level among US clinical medical faculty in nearly all specialties,[47] and across all health professions.[48] The few BIPoC who enter academic institutions report isolation, unconscious and conscious bias, lack of mentorship, experiences of microagressions and outright racism.[45,49,50] Researchers have found that RO1 research applications submitted by Black scientists were less likely to receive funding than those that were submitted by White scientists even after controlling for educational background, country of origin, training, previous research awards and employer characteristics.[51] Clearly, more assertive measures for faculty recruitment, retention, and promotion are necessary to obtain equity and inclusion.[47,50] These institutional and systemic forms of exclusion are racist and need to be addressed to make any steps toward reaching health and professional equity for BIPoC.

Addressing individual, institutional, and systemic racism in addiction

We all possess conscious and unconscious attitudes and stereotypes about race that can directly harm our patients and colleagues. When we are unaware of these racial biases and sit in positions of power, this further embeds racism into our institutions and systems. Anti-Racism refers to a set of strategies, theories, actions, and practices that challenge and counter racism, inequalities, prejudices, and discrimination based on race.[52] It is critical we practice anti-racism in our daily lives through reading and training, adoption of culturally informed treatment approaches, reexamination and sharing what is or isn't appropriate data by race/ethnicity and social determinants of health.[53] For example, many medical decisions are guided by diagnostic algorithms and practice guidelines that include adjustments for race or ethnicity. These diagnostic algorithms may propagate race-based medicine by directing resources toward Whites.[54] That said, our responsibility does not end with our own internal work and clinical practice. We must strive on a larger scale to end the institutional and structural racism that permeates the day-to-day experience of all persons who use drugs.

Stigmatizing language and negative attitudes from health professionals toward all persons who use drugs are significant barriers that diminish patient empowerment, reduce provider empathy and engagement, erode the therapeutic relationship, and result in suboptimal care.[55] For example, referring to a person who uses substances as a "a substance abuser" or "addict" perpetuates negative stereotypes and biases that drives people away from live-saving treatment and services.[56,57] The use of clinically accurate and "people-first" language, on the other hand, respects the worth and dignity of all persons and promotes engagement and the recovery process. Our use of language has the power to shape our social and public policies.[56,57] As clinicians, educators, researchers, and advocates, we hold status, power, and privilege. It is our responsibility to lead in the identification and eradication of individual and systemic racism and substance use stigma through our multidisciplinary spheres of influence, however big or small they may be.

Responses and policy options

The addiction community's collective response to the inequities for BIPoC affected by unhealthy substance use is deficient. For example, there is only a belated discussion of Black overdose deaths in the national discourse around the "opioid crisis," even though the rates of increase in opioid-involved deaths have risen more steeply among people who are Black (43%) than White (22%) over the past five years.[58] Despite the knowledge of how the war on drugs has played out in the Black community and the disproportionate impact SUDs and their complications have on BIPoC, we have failed to make adequate changes in our systems.[27,32,33] To begin to remedy both the inequities at the root of racial disparities and the dearth of

attention to BIPoC who use drugs, we must increase awareness and recognition of unconscious stereotyping and prejudice toward racial groups in healthcare. In 2020, SAMHSA released two guidance documents outlining ways to address disparities in response to the opioid epidemic for Black/African American communities and the double jeopardy Black and Latina/o communities encounter with the added disproportional risks of COVID-19 disease.[7,29] Indeed, the COVID-19 global pandemic has only further unmasked the inequities in health care for BIPoC and amplified the impact of social and economic factors that contribute to poorer health outcomes.[29] Researchers have found that COVID-19 patients with a SUD had significantly worse outcomes (death: 9.6%, hospitalization: 41.0%) than general COVID-19 patients (death: 6.6%, hospitalization: 30.1%). Further, they found that African Americans with COVID-19 and SUD had worse outcomes (death: 13.0%, hospitalization: 50.7%) than Caucasians (death: 8.6%, hospitalization: 35.2%).[59] These findings underscore the differential impact that COVID-19 has on BIPoC and further risks deepening existing health disparities.

We have reached a point in history, when we must actively and unilaterally respond to the contextual issues, disparities, marginalization, and barriers to substance use services for BIPoC. This will be done as we train in deep cultural humility and learn how to put anti-racist and anti-oppressive principles into practice. This will be done by seeking out and raising up younger BIPoC through educational opportunities and mentorship in the science of substance use and addiction. This is the duty of leaders serving together to eliminate the discriminatory policies, practices, and behaviors that undermine equity and inclusion in addiction care and services for people who use drugs. Further, we must apply anti-racist practices in the development of policies that eliminate the current discriminatory policies, practices, and behaviors that perpetuate inequities between socially-defined groups within healthcare and specifically within addiction care and other services for persons who use drugs.[53,60–62] Together, we can invest in the success of these efforts through financial support, continuous quality improvement, effective advocacy, and timely amplification. In doing so, we exercise the knowledge that those with the greatest needs and least resources require more—not equal—efforts and resources.

AMERSA's position

AMERSA's mission is to improve health and well-being through interdisciplinary leadership in substance use education, research, clinical care and policy. For this mission to be fully realized, racism and its deadly impacts must be identified and counteracted at every level within our organization and throughout the AMERSA experience. For the AMERSA BOD, and we hope for members as well, this kind of actionable change extends across personal and professional communities from the individual to the institutional to structural.

In 2015, the AMERSA BOD established a Diversity Committee to focus on increasing the diversity of AMERSA's membership and activities, including but not limited to race/ethnicity, sexual minority and health disciplines. Despite that structure, the issues affecting BIPoC were not at the forefront of the work being undertaken by the AMERSA BOD. As a result, in 2017, the Diversity Committee Chair was invited to join the BOD as an ex-officio member. Though that was an important step in raising consciousness about many of the issues outlined above, in 2020 the BOD acknowledged that a stronger position would be to establish a Diversity member-at-large (MAL) position on the BOD. That meant that the leader of this committee would not only have a voice, but a vote to ensure a focus on issues related to diversity, equity, and inclusion. The AMERSA bylaws were revised so that this critical MAL position remains permanently in place.

In past years, AMERSA collected limited demographic information from members and conference attendees. As a result, we are unable to provide an accurate description of our own racial and ethnic diversity. We aim to do better. Given our goal of increasing diversity and inconsistencies we found in our data collection, we have revised the demographic questions that we use in our conference and membership registration surveys. We will now include language that invites respondents to identify their race, ethnicity, gender, and sexual orientation, and that explains the significance of being counted. We hope this added language will encourage people to provide this information so that we can publicly share an accurate, transparent picture of the AMERSA organization and where it needs to grow.

To further promote diversity, equity, and inclusion, the AMERSA BOD recommends an initial set of strategies that align with four key AMERSA experiences: (1) Engagement; (2) Education; (3) Mentorship and (4) Leadership.

Recommendations	Strategies
Engage: Recruit AMERSA members and conference attendees who reflect the diversity of the population of those who use substances.	To more accurately describe AMERSA's current demographic profile and develop measurable diversity recruitment targets, we will survey members and conference attendees in 2021 about their racial/ethnic and gender identities using inclusive and purposeful language. We will include on our website a timeline of "Who We Are," which documents our annual progress in growing a membership that more accurately reflect the diversity of the population of those who use substances. We will conduct outreach to BIPoC health professional organizations, including Historical Black Colleges and Universities (HBCUs) and Tribal Colleges and Universities, about multidisciplinary careers driven by social

(*continued*)

Continued.

Recommendations	Strategies
	justice and the science of substance use and addiction, as well as AMERSA conferences, scholarships, mentoring programs and membership benefits.
	We will offer conference scholarships and free or subsidized AMERSA memberships to health professional students, trainees, and junior faculty from underrepresented communities.
	We will solicit philanthropic donations from noncommercial resources to support Diversity, Equity and Inclusion (DEI) scholarships and memberships. AMERSA has received an initial pledge of $10 K in 2020 from an anonymous donor for this purpose.
Educate: Learn about, teach, and disseminate anti-racism principles in substance use education, research, clinical practice, and policy.	To learn about diversity, equity, and inclusion, we will expand the racial equity lens to all of our educational activities. Specifically for the annual conference, we will continue to support the Program Planning Chairs to identify and engage high-quality speakers from historically underrepresented populations. In addition, we will ask all speakers to address diversity, equity, and inclusion in the content of their presentations.
	We will offer antiracism and diversity trainings at our meetings (e.g., skills-based workshop, film event, or book club) and/or sponsor/co-sponsor antiracist education activities throughout the year with other substance use-related professional organizations or educational programs.
	We will invite each AMERSA Special Interest Group (SIG) to examine its contributions to diversity, equity, and inclusion; we will promote on the AMERSA website and social media their accomplishments and action plans to do more within their specific health professions or foci of interest.
	In all AMERSA communications, we will require the use of "people first" language, for example, all AMERSA conference materials and presentations will be peer-reviewed for the use of people-first, clinically accurate, and non-stigmatizing language.
	We will curate and invite members to contribute to an annotated bibliography on the AMERSA website on anti-racism and advancing health equity for BIPoC and other marginalized communities affected by unhealthy substance use.
	Using AMERSA's journal and/or website, we will increase the dissemination of scholarship to expose and eradicate racial inequities in the substance use and addiction fields. To establish a baseline upon which to improve, we will request from the editorial board the number of articles SAj has published in the last 5 years on advancing the health equity for BIPoC and other vulnerable populations.
Mentor: Expand AMERSA's Mentor-Mentee program to increase participation by BIPoC clinicians, educators, and researchers, as well as students and early career professionals whose work addresses the needs of BIPoC communities affected by unhealthy substance use.	To support and advance the careers of BIPoC and others whose work focuses on unhealthy substance use in underserved populations, we will train and develop dedicated AMERSA members to serve as mentors, allies, and sponsors in the Mentor-Mentee program.
	We will launch a new sponsored program for BIPoC college and graduate school students with an interest in substance use and addiction professional careers to attend on scholarships the AMERSA conference with specifically trained Mentors. Mentees will be recruited through outreach efforts described earlier. The program will be funded by non-industry philanthropic donations.
Lead: Configure the AMERSA BOD and other leadership positions to reflect the diversity of the population of those who use substances.	We will recruit, mentor, and nominate future leaders for the AMERSA BOD and other leadership positions in the organization, who reflect the US population's diversity more accurately.
	We will require that all directors, committee chairs, Executive Director, and Deputy Director participate in regular DEI training. Specifically, we will include diversity training at the BOD annual retreats.
	We will actively rebuild the Diversity Committee to foster, promote, and incorporate the benefits of strengthening diversity in all AMERSA's activities.

The AMERSA BOD commits to these actions. After all, liberation requires instilling equitable care that respects differences.[63] No human life is superior to another in its logical, epistemological, educational, and political dimensions.[63,64] Because humans are all different, these differences are precisely the reason we need to establish equity.[63,64] Ignoring the pervasive structural racism that exists in the field of substance use and addiction and in the larger health care systems and communities will only deepen the chasm in our society between White and BIPoC. The time to act is now. As the late Representative John Lewis reflected, "You filled me with hope about the next chapter of the great American story when you used your power to make a difference in our society".[65] The AMERSA BOD, through the actions outlined in this position statement, stand in solidarity with BIPoC and all persons who use drugs across the substance use spectrum of harm reduction, prevention, intervention, treatment, and recovery; committing to promoting equity and inclusion.

To be transparent and accountable, we will publish an annual update on the progress of our recommendations and strategies by publishing on our website and promoting

through our social media outlets specific metrics on our diversity and inclusion efforts. We will include in our report: membership demographics, conference attendee demographics, the action steps we took toward our recommendations, and outcome metrics overtime.

The AMERSA BOD cannot achieve this alone. We invite our members to join us in building an inclusive, multidisciplinary professional society equitable for all. Please send us your feedback and ideas for actions that will hold us accountable. Contact us by emailing any of the AMERSA BOD or the National Office at info@amersa.org.

ORCID

Holly N. Hagle http://orcid.org/0000-0003-2581-533X
Deborah S. Finnell http://orcid.org/0000-0001-7678-9640
Jeffrey P. Bratberg http://orcid.org/0000-0002-2240-5768
Adam J. Gordon http://orcid.org/0000-0002-2453-8871

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